

**CHOLINESTERASE ANALYSIS REPORT****MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE R 325.62

**LABORATORY INFORMATION:**

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PATIENT INFORMATION:**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

HOME ADDRESS STREET \_\_\_\_\_ APARTMENT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**RACE** (Check one)

- ☐ White  
☐ Black  
☐ Asian  
☐ Native Hawaiian/Pacific Islander  
☐ American Indian  
☐ Alaskan Native  
☐ Mixed

**GENDER**

- ☐ Male  
☐ Female  
☐ Unk

PHONE \_\_\_\_\_

**PARENT/GUARDIAN NAME:****ETHNICITY**

- ☐ Non-Hispanic  
☐ Hispanic

Last \_\_\_\_\_ First \_\_\_\_\_

**EMPLOYER INFORMATION** (If available)

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**SUBMITTER/PROVIDER INFORMATION:**

PROVIDER NAME \_\_\_\_\_

FACILITY \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**SPECIMEN AND ANALYSIS INFORMATION:****DIAGNOSIS** (If available) \_\_\_\_\_**SPECIMEN COLLECTION DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_**TEST ORDERED:** ☐ AChE ☐ PCHe**SPECIMEN ID** \_\_\_\_\_**ANALYSIS DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_**RESULT:**

	Value	Units	Default Units
AChE			U/g Hemoglobin
PCHE			U/L

**LABORATORY NORMAL RANGE:**

	Low	High
AChE		
PCHE		

Submit to: Michigan Department of Community Health, Division of Occupational and Environmental Epidemiology, PO Box 30195, Lansing, Michigan 48909 • Fax (517) 335-9775 • Phone (517) 335-8350